ITB 10-X-2193986
Questions Submitted to Medicaid by 08/03/09

** Asteriks designate components that require an amendment to the ITB

Row	Page #	Section	Question and Answer
01	General		Previous MCP focus studies have indicated that the average time from a patient submitting a Medicaid application to Medicaid approval is seven days in our district, so why is the additional requirement of an Application Assister in every county/district necessary? AMA Response: The purpose is to assist the recipient to gain access to the earliest possible entry into the care system and promote better birth outcomes. Needs change on a daily basis and having someone trained and prepared to intervene if the need presents itself will just be an adjunct to your care delivery system. Additionally the services are to be available if needed to improve rapid eligibility. Some districts will need more help, others less.
02	General		Comment: It will be impossible to remain budget neutral if Primary Contractors are required to review 70% (calculated from the chart) of the records for the quality measures mentioned and to provide Application Assisters in each county AMA response: There appears to be a misunderstanding about the Application Assisters. The PC is required to have application assisters to assist the maternity recipient but not every day in every county. Please refer to answers to questions 89, 90, 91 and 92 as they relate to the chart and sampling.
03	General		Will Medicaid release a maximum bid rate for each district? AMA Response: A maximum bid for each district will not be released.
04	General		Currently, the ITB is posted in PDF; will it be released on disk or on the Medicaid website in Word format? AMA Response: Yes, we will release the ITB in word format to those individuals that submit such in a written request to the AMA contact person.
05	General		Is payment to the Contractor based on the Medical Panel? AMA Response: No, the award of the ITB and payment is based on compliance with the requirements set forth in the ITB. The Primary Contractor has responsibilities of establishing a provider network, providing care coordination and meeting the needs of the Alabama Medicaid Maternity population.
06	General		Is there a business size standard? AMA Response: No.
07	General		Where will the facilities be located? AMA Response: This decision is up to the Primary Contractor based upon the established network and district.
08	ITB	Attachment I, Maternity	As the primary contractor will not be responsible for in-patient hospital expenses under this contract, is this form still valid/needed by the primary

		Care Program Operational Manual, Attachment 1 Extended Days Notification Form (Hospital In-patient Days)	contractor AMA Response: Yes. The Primary Contractor as well as the Care Coordinator needs to have an understanding of the process for additional inpatient days. The form will be revised to reflect that the hospital will be responsible for the completion of the Extended Days Notification Form.
09	ITB, p. 00	Attachment D, Evaluation Checklist, #4	Can you give an example of an unallowable external document? For instance is a reference to ACOG guidelines permissible AMA Response: An example of an unallowable document would be one that is not recognized as evidence based according to today's standards of care. Reference to ACOG guidelines is permissible.
10	ITB, p. 05	Section I, 1.1	Medicaid will enter into one contract for a three year period with the option of two one-year options for extending this contract at the original contract price. The Medicaid contract with hospitals is for two years. Why is there a difference in the duration of the two contracts? AMA Response: Since hospitals are outside of the maternity contracts there is no reason for correlation.
11	ITB, p. 06		Schedule of Activities. Will Medicaid consider changing the dates to allow more than 14 days from the "Posting of Response to Final Questions" to the "Bids Due" date? AMA Response: No.
12	ITB, p. 06	2, 3.37 Retention and Storage, 3rd paragraph	In 2008 the same CFR was referenced and stated a five (5) year retention period. This ITB says three (3) year. Is it 3 years or 5 years AMA Response: Three years
13	ITB, p. 06	Section 1.1.3 Schedule of Activities	Could a copy of the ITB in 'Word' format be posted on Medicaid's website prior to the mandatory Pre-Bid Conference on August 24? AMA Response: We will release the ITB in word format to those individuals that submit a written request to the AMA contact person
14	ITB, p. 06	Attachment 1.1.3 Schedule of Activities	Could a copy of the pre-bid question responses be posted on Medicaid's website prior to the Pre-Bid Conference due to the fact that it does not occur until the latter part of the Schedule of Activities? AMA Response: Yes.
15	ITB, p. 15	Section 1.1.14 Subcontract	If the use of subcontractors is necessary to meet bid requirements, the Letter of Intent to Subcontract from each subcontractor, shall be attached to the Transmittal Letter, signed by an individual authorized to legally bind the subcontractor to perform the scope of work as assigned,… • Does this mean that an authorized person may sign the Letter of Intent on behalf of an anesthesia or radiology group without having the signature of each individual Medicaid provider?

			AMA Response: Yes, if the person is legally authorized to make such transactions. What about DHCP group practices? Is one authorized signature acceptable or should there be one signed by each DHCP? AMA Response: One authorized signature if the person is legally authorized to make such transactions.
16	ITB, p. 15	Section1.1.14. d. Subcontracts and ITB Attachment E1.	The rate or methodology (if a varying rate is to be paid) of reimbursement to be received for the subcontractor's efforts. • Is it still acceptable to indicate "To be negotiated upon contract award" or "No less than 100% of the Medicaid fee-for-service urban rate" or "An agreed upon global rate" as the 'Payment Arrangement' in the Letter of Intent to Contract? AMA Response: Yes.
17	ITB, p. 18	2.0 Purpose	"The inpatient hospital will be outside of the global contractor reimbursement for maternity care". Is outpatient hospital care outside of the global contractor reimbursement for maternity care? AMA Response: All hospital care inpatient or outpatient is outside of the global PC reimbursement with the exception of professional components for example, those billed by anesthesia and/or radiologist. If the outpatient component is a part of the Primary Contractors responsibility, how does Medicaid expect the Primary Contractor to negotiate equitably for Hospital outpatient services without the leverage of a global payment for all hospital services? AMA Response: Not applicable.
18	ITB, p. 26	Healthcare Professional Panel, Provider Network, b. ***	The statement reads "the primary contractor must offer participation opportunities for 30 days after contract award and for the first month of each succeeding contract year....". As the initial contract award is scheduled for 10/1/2009 with a actual initial contract start date not until 1/1/2010, would it not be more appropriate to schedule the initial open enrollment opportunity closer to the actual contract start date versus the award date? In most cases the open enrollment period will mostly be for additional interested providers who did not sign initial letters of intent at the time the bid was submitted. AMA Response: The ITB will be amended to allow the initial open enrollment period for the thirty days prior to the contract start date of 1/1/2010.
19	ITB, p. 27	h	Reads: "Primary Contractor is held accountable for any functions and responsibilities that it delegates to any subcontractor." This requirement was

			questioned in the previous two ITBs and was subsequently struck from ITB. Will Medicaid please strike this requirement again, since this poses a tremendous liability issue? AMA Response: No, this is a managed care requirement.
20	ITB, p. 27	Section 2.2.5 H. Provider Network	Primary Contractor is held accountable for any functions and responsibilities that it delegates to any subcontractor. • Could consideration be given to rewording or omitting this statement due to the liability imposed upon the Primary Contractor? AMA Response: No, this is a Managed Care requirement.
21	ITB, p. 31	Attachment I, Maternity Care Program Operational Manual, Section V Services, Part C.9 Excluded Services--Covered Fee-for-Service Outpatient Emergency Room Services	Will this exclusion apply to Labor and Delivery Observation Room visits as well and be billed fee-for-service to Medicaid as outpatient charges? AMA Response: Yes. All inpatient and outpatient hospital charges are excluded.
22	ITB, p. 31	Section 2.2.6 Excluded Services	The following services are excluded from the Maternity Care Program global payment as further defined in the Operational Manual and are reimbursed by Medicaid as fee-for-service, as applicable: a. Inpatient Care f. Radiology services with the exception of maternity ultrasounds. Maternity ultrasounds are unlimited in number and are a component of the global fee payment. • Is the Primary Contractor responsible for medically necessary ultrasounds completed during an inpatient hospital admission? AMA Response: No. • If ultrasounds completed during an inpatient hospital admission are considered a part of the per diem rate, what about the professional component (reading) of those ultrasounds? Is the Primary Contractor responsible for reimbursement to the radiologist for the 'reading' of those ultrasounds? AMA Response: Yes

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23	ITB, p. 32	High Risk Deliveries	How will teaching facilities distinguish which deliveries are high risk and which deliveries are routine? Is it correct that Primary Contractor can bill for routine deliveries at teaching facilities? AMA Response: Any delivery occurring at high risk facilities will be billed fee for service and will not be in the global payment from the PCs. Submitted bids should reflect this change. Yes, the PC will continue to bill a global which should now factor in this change. Hence, we would anticipate competing bidders would be able to offer a smaller global because of this decrease in their cost.
24	ITB, p. 32	Attachment I, Maternity Care Program Operational Manual, Section V Services, Part C.16.b. Excluded Services--Covered Fee-for Service Care Provided at Teaching Facility	Can you please elaborate on this section? Are any patients assigned to treatment/delivery primarily at a teaching facility going to be excluded from the global fee/ITB and the pregnancy in total be paid fee-for-service or just those patients that are risk assessed as "high risk"? AMA Response: Services provided to any patient who delivers at a teaching hospital (as defined in the State Plan) will be billed directly to Medicaid by the teaching facility and the teaching physician.
25	ITB, p. 32	b. High Risk Protocols	Are any pregnancies that cannot be managed by a non-specialty provider and are therefore referred for care at a teaching facility considered high risk or are there specific criteria? AMA Response: A medical provider (DHCP) will decide if the recipient is high risk and that care cannot be provided in the district. There are no specific high risk criteria.
26	ITB, p. 32	b. High Risk Protocols	If a recipient is deemed high risk and referred to a teaching facility after some care has been rendered at a routine prenatal care site, how is the routine care reimbursed? What about Care Coordination for high risk patients? How will it be reimbursed? AMA Response: If the patient meets the exemption criteria found in the Operational Manual, Section, V.D. routine care will be reimbursed fee-for-service. If the recipient is exempted the Primary Contractor would bill the drop out fee. If the patient is not exempted, the cost to the Primary Contract would be less, hence, we would anticipate competing bidders would be able to offer a smaller global because of this decrease in their cost.

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27	ITB, p. 32	b. High Risk Protocols	Does the ITB consider high risk providers not affiliated with a teaching facility? What is the payment structure for these providers? If a recipient is referred to a high-risk provider that is not at a teaching facility and the provider does not deliver, must the recipient be exempted and how would the DHCP (who referred for high-risk care and would be delivering) be reimbursed? AMA Response: Question 1. There is no special consideration for high risk providers not affiliated with a teaching facility. The payment to a high risk provider is to be negotiated between the Primary Contractor and the provider. Question 2: The care would be a component of the global. The Primary Contractor would be responsible for paying for the high risk consult out of the global.
28	ITB, p. 32	b. High Risk Protocols	Primary Contractors must manage high risk pregnancies, including …..a network for care, policy and procedures for monitoring referrals and services to be provided to high risk women. Define "a network for high risk care". Will Primary Contactor be required to have high risk contracts? Is the expectation of the Primary Contractors to manage high risk pregnancies, in that high risk is excluded from the global? AMA Response: A network for care is a mechanism for meeting or ensuring that patient needs are met. The PC must ensure that high risk needs are met. The coordination of high risk care is not excluded from the global, but payments to teaching facility physicians are excluded.
29	ITB, p. 33	2.7, Reimburse-ment for Services, 2nd paragraph	"For recipients who receive total care through the Primary Contractor network, a global fee should be billed." If total prenatal care is given by the DHCP and the patient looses her insurance or just doesn't qualify for Medicaid until the end of the pregnancy or after delivery; then, subsequently gets retro-Medicaid, does the Primary Contractor bill for the full global or delivery only? AMA Response: Delivery only
30	ITB, p. 33 And Op Manual	Section 2.2.7 Reimburseme nt for Services VII.A. P.26 Section IV. G.3. Program Enrollment ****	Op Man: The components of the delivery-only fee include those services provided from the time of delivery through the postpartum period. OM: If the delivery has occurred, there is no reason to enroll the recipient. • Is the hospital face to face encounter by the Care Coordinator required as a component of the delivery-only fee? AMA Response: Yes, an amendment will be made to the Operational Manual.
31	ITB, p. 33	2.7, Reimburseme nt for Services 2nd paragraph	"For recipients who receive total care through the Primary Contractor network, a global fee should be billed What is considered to be total care? AMA Response: Care from the first visit through the post partum period with the exception of inpatient and outpatient hospital facility services, referrals to specialists, labs/x-rays, and pharmacy charges that are billed fee for service.

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32	ITB, p. 34	2.2.7. Delivering Health Care Professional Payment	Is it correct that the Primary Contractor's only responsibility to a physician associated with a teaching facility would be the rate for delivery only ($1,161) and caesarean delivery only ($1,383)? AMA Response: No, the physician would bill fee for service. The PC would bill the global unless there was an exemption.
33	ITB, p. 36		"Application Assister services." Considering the cost that would be required in the global fee, are Primary Contractors expected to hire "Application Assisters," pay rent space, supplies, travel, etc., in counties where there is no DHCP, delivering hospital, or Care Coordinator? Maybe the requirement could be that all CC's were trained to be Application Assisters. AMA Response: Question1, No. The intent is to have staff trained as application assisters and assist the recipient to gain the earliest entry date as possible into care, but we are not specifying which staff. Some districts may train their CC's while others may find another mechanism is better for them.
34	ITB, p. 53 **	Attachment I, Maternity Care Program Operational Manual, Section IX Quality Assurance and Performance Improvement, Part C Service Database	The section states that <u>all</u> data entry on a patient must be completed within 60 days of delivery date however this conflicts with postpartum visit completion dates, etc in which some information is needed from this visit to complete the full database entry. For example, the database requires data regarding the outcome of the postpartum visit and breastfeeding at that visit however the manual states the acceptable range for postpartum visits should occur between 21-60 days post delivery. Can adjustments to the data completion date be postponed by 5-10 days in order for the primary contractor to have time to gather postpartum info and ensure entry into the data system as required by the ITB AMA Response: Yes, the ITB will be amended to include within 90 days.
35	ITB, p. 64	3.42 Clinical Laboratory Improvement Act	Please clarify the primary contractor's responsibility as to what laboratory sites you are referring to that the contractor must ensure are CLIA certified/waived. Under the ITB specifications, the only labs covered under the primary contractors' responsibility is hemoglobin, hematocrit and urinalysis with all other labs being covered fee-for-service by Medicaid and usually being sent out from the MD offices to various reference laboratories. Are you referring to just those labs covered by the global fee that are usually performed in the MD office are CLIA certified/waived or any reference lab the DHCP utilizes for the fee-for-service labs as well? AMA Response: This is a Managed Care requirement. The AMA expectation would be that you have this information in the contract for subcontractors which restates the requirement. The Subcontractor has the responsibility of following through with the laboratory he/she utilizes or if the provider does lab on site, he/she must have the appropriate CLIA credentialing.
36	ITB, p. 64	CLIA	Since most lab services are outside the global fee and Primary Contractors are not a part of the contract arrangements between subcontractors and lab service providers, how can Primary Contractors ensure or have influence over this? AMA Response: This is a Managed Care requirement for your subcontracts.

			The AMA expectation would be that you have this information in your contract with the subcontractor restating this requirement. The subcontractor has the responsibility for following through with the laboratory or if the provider does lab on site they must have an appropriate CLIA number.
37	N/A	N/A	Will Medicaid post the answers to these questions as soon as they answer them, as they did last year? AMA Response: The questions which are received prior to the pre-bid conference will be posted to the AMA website.
38	Op Man	Attachment 5	Application Assisters – Clarify the role of Application Assisters. Will recipients continue to go to the SOBRA worker first (as is the case in most instances) and the Application Assister become involved if the patient encounters barriers? AMA Response: We anticipate that Application Assisters will facilitate the earliest possible entry into care. The order of contact with the SOBRA worker is irrelevant. The process should be according to what or how the earliest entry into care can be met.
39	Op Man	Attachment 2. Agreement to Receive Care	Are alterations to this form still permissible as long as all the information on Attachment Two is retained? AMA Response: Yes
40	Op Man	Attachment 3. Global Associated Codes	Since fetal non-stress test (59025) is listed in the Global Associated Codes, what responsibilities does the Primary Contractor have to the hospital providers for this procedure when it is performed on an outpatient basis? AMA Response: The PC would have the responsibility to reimburse for only the professional components.
41	Op Man **	Attachment 3. Global Associated Codes	Since excision abdominal pregnancy (59130) and removal of ectopic pregnancy (59130) are now included in the Global Associated Codes, how would the Primary Contractor bill for these services AMA Response: This code will be removed from the Global Associated Code list through an amendment.
42	Op Man, p. 11	5.	"Any Delivering Health Care Professional must have hospital privileges at a participating hospital within the Maternity Care program district." With hospitalization not included with the Maternity Care Program and therefore no contract between Primary Contractors and hospitals, how does Medicaid expect Primary Contractors to obtain (time intensive on the hospital side) DHCP hospital privileges <u>in good standing</u> from hospitals? AMA Response: The Primary Contractor must contain a provision in its subcontract with DHCP's that the physician must notify them in the event of change in his/her hospital privileges.
43	Op Man, p. 11	Attachment I, 5.	"Postpartum care includes inpatient hospital visits, …" Is the Primary contractor responsible for Inpatient and Outpatient hospitalization postpartum care visits? If no, would Medicaid consider changing to say. "Includes DHCP inpatient hospital visits . . ."

			AMA Response: This section does not specify physician services but implies this because it is documented that inpatient hospital care is not a component of this contract. Additionally the care coordinator or designee is required to make a face to face visit to the recipient in the hospital post delivery.
44	Op Man, p. 11	III.A.2	Do the hospitals from which DHCPs are delivering have to be within the 50 mile radius? AMA Response: No. What if ultrasounds are provided outside the DHCP's office? Must this service be offered within this radius as well? AMA Response: If the procedure is provided in a hospital as indicated above, No.
45	Op Man, p. 11	III.A.5	If a Program recipient lives near the Alabama / Mississippi state line and her physician delivers at a hospital in Mississippi, is there any mechanism for the Mississippi hospital to be reimbursed? AMA Response: Yes for those bordering hospitals within thirty miles of the state line and if the DHCP has admitting privileges.
46	Op Man, p. 11	III.A.5	Will all hospitals within the districts be participating hospitals within the Maternity Care program district? If not, how will we determine which hospitals are "participating". Will these hospitals have the ability to refuse to provide services (whether inpatient or outpatient) to particular bidders? AMA Response: Question 1: All Medicaid enrolled hospital providers which offer delivery services would be considered participating providers. Question 2: Hospitals have their own requirements surrounding admission privileges of physicians. The physician providing the care will be the key.
47	Op Man, p. 12	Section III. A.9. Standards for Primary Contractors	Require all subcontractors providing direct services to meet the requirements of and enroll as Medicaid providers as applicable. This will include any professionals that provide on-call coverage for the network provider. • An historical provider utilizes the services of an on-call physician who is not an Alabama Medicaid Provider and does not choose to become an Alabama Medicaid Provider. Does this mean that the historical provider can no longer participate in the Maternity Care Program if they continue to utilize the on-call services of the physician who is not an Alabama Medicaid Provider? AMA Response: The historical provider cannot continue to participate.
48	Op Man, p. 17	III.F	The last sentence of the first paragraph provides that "Primary Contractors must provide all medically necessary services as covered services following Medicaid policies and procedures." Should this language be revised to limit the responsibility of Contractors to pay for the services set forth in Section 5.B of the Operational Manual? AMA Response: Our interpretation is that Section 5B denotes AMA covered services and we do not feel that the language requires revision.

49	Op Man, p. 17	III.F.2	What does "consistent with other like contractors" mean with respect to the reimbursement rate offered to willing subcontractors? AMA Response: The AMA expectation is that the amount offered must be consistent with the minimum reimbursement rates specified in the ITB. For example, providers must be paid at a rate no less than the Medicaid fee for service urban rate which is $1000 for delivery only. It is up to the Primary Contractor and the physician to negotiate rates beyond the minimum in this example.
50	Op Man, p. 19	Section III.G.5. Subcontractor Requirements	Subcontracts executed for the purposes of meeting program requirements must meet the following requirements: Contain a provision specifying that provider must agree that under no circumstances (including, but not limited to, situations involving non-payment by the Primary Contractor, insolvency of the Primary Contractor, or breach of agreement) shall the provider bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against Medicaid recipients, or persons acting on their behalf, for covered services, rendered during the term of provider's agreement or sub-contract amount with the Primary Contractor. A provider may charge for non-covered services delivered on a fee-for-service basis to Medicaid recipients. If a subcontractor has a recipient sign a document acknowledging that they are aware of the need to enroll in the Maternity Care Program and accepting responsibility for prenatal care charges if they do not enroll, can that subcontractor bill that recipient in the new contract period? AMA Response: Yes
51	Op Man, p. 29	d. Postpartum	Operational Manual, p. 29, d. Postpartum.: "Postpartum care includes inpatient hospital visits…" Since this section does not specify physician services, can it read, "Postpartum care includes *DHPC* inpatient hospital visits…"? AMA Response: This section does not specify physician services but implies this because it is documented that inpatient hospital care is not a component of this contract. Additionally the care coordinator is required to make a face to face visit to the recipient in the hospital post delivery.
52	Op Man, p. 29	Attachment I, D.	"Home visits are optional." The award of the bid for the Maternity Care Program is low bid first, then validation of technical responsiveness. In a situation with more than one bidder, will Medicaid take into consideration the increased bid dollars related to Home Visits being an enhancement of the program? AMA Response: No. The expectation is that all bidders will take into consideration the possibility of home visits. Home visits are a program requirement in the event of a missed face to face hospital visit and are not considered to be an enhancement.
53	Op Man, p. 29	V.B.9.d	If DHCP's send patients to hospitals or other facilities for ultrasounds, must the Provider produce subcontracts with these facilities for the provision of such services? AMA Response: No for hospitals and yes for other facilities.

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54	Op Man, p. 30 ***	2. Drugs, 2nd paragraph	The second sentence states,"Drugs which are administered in an in-patient setting or ambulatory surgical center setting are included in the global fee." Should this be "excluded in the global fee" since this is fee-for-service? AMA Response: This sentence will be deleted per amendment.
55	Op Man, p. 30 ***	Attachment I, j.	"All data entry on a patient must be completed within 60 days of the delivery date." Earlier in the Operational Manual on page 29 d. it states "the postpartum Delivering Health Care Professional exam shall be accomplished between 21 to 60 days after delivery." If Medicaid is allowing DHCP's to have up to 60 days to perform the postpartum exam, how can Medicaid expect the Primary Contractor to not only gather the data, but key the data and upload it to be compliant? Would Medicaid consider a 30-60 day delay in submission of Service Report data to ensure more accurate and complete data? AMA Response: Yes, Medicaid will allow an additional thirty days from the delivery date for completion. Medicaid will amend the contract to reflect this change.
56	Op Man, p. 31	V.C.9	If a patient presents in labor and delivery and the hospital provides care related to false labor and/or provides care that is subsequently deemed non-emergent, are these costs incurred by the treating hospital or the responsibility of the Primary Contractor? AMA response: The facility cost is billed directly to Medicaid; the professional component is the responsibility of the Primary Contractor.
57	Op Man, p. 32	Excluded Services #16	If a patient does not meet the criteria for a medical exemption, but goes into pre-term labor and is transported to USA or UAB where they deliver, does the Primary Contractor file the global fee to pay for other subcontractor services such as local DHCP, care coordination, administration, home visits, ultrasounds, etc.? AMA Response: Yes.
58	Op Man, p. 32	V.C.16. High-Risk	If a teaching facility was the district's only high-risk provider, would a high-risk exemption ever be necessary? AMA Response: No.
59	Op Man, p. 32	V.C.16. High-Risk	Will the Primary Contractor be required to include Letters of Intent in their bid response from physicians (DHCPs and/or Anesthesiologists) associated with a teaching facility for delivery only services? AMA Response: No.
60	Op Man, p. 33	V.D.1	Are exemptions for high risk care provided at UAB Hospital and/or UAB Maternal / Fetal Medicine required? AMA Response: No

61	Op Man, p. 34	VI.D.2.a	When a Program Recipient has one or two visits to a specialty provider and is then returned to an in-network contractor, please clarify whether the Primary Contractor will be responsible for cost of the specialty provider services or just the post specialty treatment care? AMA Response: Office or in-hospital visits provided by non-OB specialty physicians for problems complicated or exacerbated by pregnancy can be billed fee-for-service.
62	Op Man, p. 35	VI., A.	Care Coordinators are required to assess the patient face to face at a minimum of two visits. If the patient meets the minimum requirements and is seen upon enrollment but the in-hospital visit is missed, will the mandatory home visit count for the second face to face encounter? Also, if additional encounters are deemed appropriate, are phone encounters satisfactory? AMA Response: The home visit is counted as a face to face encounter. Additional encounters may be phone encounters or face to face depending on the needs of the patient.
63	Op Man, p. 36	Section VI.B.5. Requirements for Maternity Care Coordinators	Recipients in counties where there are no Maternity Care Providers physically located choose a prenatal care site from the Delivering Health Care Professional List (Provider Network). The recipient is assigned to a Care Coordinator associated with the chosen provider. If Care Coordinators serve as Application Assisters, can the Care Coordinator assigned be considered the Application Assister available to that recipient although they may not be located in the same county? AMA Response: Yes.
64	Op Man, p. 36	Section VI,B.5. Requirements for Maternity Care Coordinators	The Primary Contractor has flexibility in determining how to perform the Application Assister function. Care coordinators are not required to be Application Assisters; however, the Application Assister function is required to be performed by the Primary Contractor. The Primary Contractor may choose to use a Care Coordinator for this function, while others may choose to have other staff provide this function. Application assister training is provided free of charge by Medicaid Agency staff (Attachment Five). There are no Maternity Care Providers physically located in some counties within a given district. Therefore, additional staff will be required as well as the expense of office space and travel time. Will Medicaid take into consideration the expense that will be incurred by the Primary Contractor in making arrangements to place an Application Assister in a county where no provider is physically located? AMA Response: The AMA expectation is that the bidder meets the requirement of the ITB. There is no specific requirement that an application assister be physically located in each county only that the PC offer/provide this function to all maternity patients.
65	Op Man, p. 36	Section VI.B.5. Requirements for Maternity Care Coordinators	Will the Primary Contractor be eligible to receive the reimbursement currently available for the provision of Application Assister services? AMA Response: Medicaid is limited to who they may reimburse for application assister functions. Medicaid may reimburse public disproportionate share hospitals for application assister functions.

66	Op Man, p. 37	Section VI.C. Initial Encounter	Time frame: Entry into care Enrolled 0-6 weeks gestation - this encounter should be no later than 21 days after enrollment date Enrolled 7-14 weeks gestation - this encounter should be no later than 14 days after enrollment date. Enrolled 15 weeks gestation or more - this encounter should be no later than 7 days after enrollment date. If enrollment date is the date that the recipient signs the "Agreement to Receive Prenatal Care," and this form is signed during the Initial Encounter, should these time frames specify "no later than 21 days after entry into care" rather than enrollment? AMA Response: In this instance the date of entry into care would be equivalent to the enrollment date.
67	Op Man, p. 39	ff	Regarding the postpartum hospital encounter. We have several small rural counties that have less than 100 deliveries per year and the DHCP sees his/her maternity patients one (1) day a week. We have a care coordinator in that area for his/her office hours only. The small hospital staff is usually not available for the postpartum hospital encounter. Is there another way for these counties to conduct the postpartum encounter in order to defray the expensive costs of staff and travel to do a home visit for patients who were missed during the hospital delivery stay and live over 30 miles away from the nearest staff? AMA Response: No, but the post partum visit could be conducted by PC staff who could visit the hospital before discharge.
68	Op Man, p. 39	VI.D. Subsequent Encounters	The other encounter must occur while the mother is still in the hospital after delivery. A delivery occurs at a teaching facility, out of town, or out of state, and the Primary Contractor is not notified. Therefore, a visit in the hospital prior to discharge is not possible. The Primary Contractor does not receive claims for the delivery in a timely manner. What would be the responsibility of the Primary Contractor since a home visit would not have been arranged? How would cases such as this be factored in determining compliance with Agency expectations? AMA Response: The expectation would be that the PC tracks dates of confinement and follows the patient in order to arrange home visits in similar situations. The PC would be expected to make 2 home visit attempts with supporting documentation of why if this visit is not successful. Compliance will be based on the supporting documentation.

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69	Op Man, p. 39	VI.D. Subsequent Encounters	A new mother is not readily accessible during the inpatient delivery stay. Is there any possibility that consideration could be given to allowing the hospital encounter to be completed by telephone if a face to face encounter is not possible? AMA Response: No
70	Op Man, p. 39	VI.D	The first paragraph provides that the second required encounter must occur while the mother is still in the hospital after delivery. Must the care coordinators provide this service or can other qualified individuals do so (e.g.nurses, experienced staff)? AMA Response: Other qualified staff may complete the visit but the expectation is that the required elements are met in conjunction with the visit.
71	Op Man, p. 39	VI.D.2-3	Is the Primary Contractor now supposed to review a Program Recipient's medical records prior to a meeting and review physician recommendations/ diagnosis/high risk factors with the Program Recipient? Care Coordinators are typically not nurses or other medical professionals. There is some concern that patients could be advised incorrectly of these matters or that other questions will arise that should have been addressed with a medical provider, thereby placing the care coordinator in an uncomfortable position. Is it Medicaid's intent for care coordinators to provide interpretation of medical orders? AMA Response: It is not the intent of Medicaid for anyone to function outside their professional scope of practice. However, one of the many roles of the Care Coordinator is coordination of care. If a Care Coordinator is not qualified to provide interpretation of medical orders, they are to coordinate seeing that the needed services are supplied by a qualified person on the care team.
72	Op Man, p. 40	#13	Assist the patient in completing the Patient 1st Newborn Choice Form (Attachment 10). A copy of the hospital information and the Medicaid Patient 1st Newborn Choice Form should be faxed to the selected health care professional at the time of the hospital visit." As requested by the Medicaid Maternity Care Program, Care Coordinators are currently asking about the choice of newborn's physician earlier in the pregnancy than delivery. The moms-to-be are told to complete the Patient 1st Newborn Choice Form and mail it to Medicaid as soon as possible so the mother can best ensure that her newborn gets her choice of pediatrician before the pediatrician has reached her maximum caseload. If the Care Coordinators complete this form at the delivery (postpartum) hospital visit and mail it to the pediatrician and the pediatrician happens to be filled up, this could create confusion for the pediatrician and patient. Currently, if the patient does select a certain pediatrician, the pediatrician is notified when the hospital sends the infant's inpatient information to the pediatrician. Will Medicaid reconsider the wording of this requirement to read, "If not already done, assist the patient…"? AMA Response: The goal is to improve the hand off of the infant to the pediatrician at delivery. The Care Coordinator must coordinate with the hospital sending the infant's inpatient information to the pediatrician.

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73	Op Man, p. 40	VI.D.13	The last sentence of this paragraph provides that "A copy of the hospital information and the Medicaid Patient 1st Newborn Choice Form should be faxed to the selected health care professional at the time of the hospital visit." Please clarify what is meant by "hospital information", "selected health professional" and "hospital visit" in the previous sentence. AMA Response: Hospital information is considered to be copies of pertinent information pertaining to the mother/infant, selected health professional would be the chosen Patient First Physician and hospital visit is the face to face hospital encounter required of the care coordinator.
74	Op Man, p. 40	VI.D.13	The last sentence of this section requires faxing of the Patient 1st Newborn Choice Form. What if the patient does not, for whatever reason, select a pediatrician prior to delivery? AMA response: The Mom should be encouraged to make the selection at the time of the face to face hospital encounter.
75	Op Man, p. 42	VI.H	In the 2008 Operating Manual, there was a separate code for each of the four required encounters and an additional one for "all encounters". In the 2009 Operations Manual, there is a separate code for five different encounters. Please confirm that there is no expectation that five encounters be conducted for each Program Recipient and advise as to whether there is an all-inclusive code as existed in previous contract periods AMA Response: No, the expectation is not that five encounters be conducted. The Care Coordinator has been given the flexibility to determine and provide the appropriate number of visits based on the recipient needs. The all inclusive code will not be added.
76	Op Man, p. 43	VII.A.	Home visits are optional. If two bids are submitted identically except Bidder "A" has home visits included with a bid of $3,010 and Bidder "B" excluded home visits with a bid of $3,000, who will the contract be awarded to: Bidder A or Bidder B? AMA Response: The proposed bidder must meet the requirements of the contract. Home visits are optional. The bid must include a plan for home visits if the hospital face to face visit requirement is unmet. The AMA expectation is that the prospective bidder provides the level of service that is needed to meet the recipient's needs. The contract would be awarded to the lowest responsive bidder.
77	Op Man, p. 43	VI.A. Home Visits	If the hospital face to face encounter visit is missed, a home visit must be made. If the delivery occurred at a teaching facility, out of town, or out of state, and a home visit was not possible due to inaccessibility to mother and infant, how would that be calculated in determining compliance with the Agency expectations? AMA Response: Refer to question 68 above.

78	Op Man, p. 43 **	VII.A.	Is there a specified time frame for the completion of a home visit required if the hospital face to face encounter is missed? For example, currently home visits must be completed within 20 days of discharge AMA Response: Yes, twenty days. The ITB will be amended to include this standard.
79	Op Man, p. 43	VII.A.	In the current contract period, a home visit is not required if the recipient and/or infant has seen a medical professional within the stated timeframe unless additional needs are determined. The hospital face to face encounter visit is missed. Following discharge, a recipient sees a medical professional, and family planning is addressed. Is a home visit required? AMA Response: Yes. The expectation is that the home visit would be utilized to meet the requirements/elements required for the encounter visits.
80	Op Man, p. 43	VII.A Home Visits	If the hospital face to face encounter visit is missed, and a home visit is attempted, what would be considered adequate documentation of a home visit attempted but not completed due to patient non-compliance? AMA Response: At a minimum the Care Coordinator documentation must support the attempt of one physical visit, followed up by two phone attempts with the recipient, and lastly a certified letter indicating to the recipient the unsuccessful attempts.
81	Op Man, p.43	VII. A. Home Visits	How would home visits attempted due to a missed hospital encounter but not completed be considered in the calculation of penalties imposed related to Care Coordination encounters not meeting the expectation of 90% completion rate? AMA Response: If the documentation supports all efforts were exhausted in an attempt to make the visit, it will not be included in the 90% calculation.
82	Op Man, p. 12	Section III. A.9. Standards for Primary Contractors	Require all subcontractors providing direct services to meet the requirements of and enroll as Medicaid providers as applicable. This will include any professionals that provide on-call coverage for the network provider. • An historical provider utilizes the services of an on-call physician who is not an Alabama Medicaid Provider and does not choose to become an Alabama Medicaid Provider. Does this mean that the historical provider can no longer participate in the Maternity Care Program if they continue to utilize the on-call services of the physician who is not an Alabama Medicaid Provider? AMA Response: The historical provider cannot continue to participate.
83	Op Man, p. 45	VII, C.	MCP Operational Manual pg. 45,: Subcontractor Reimbursement – Regarding payment of all claims within 60 days of delivery, if a patient is a delivery only patient and is not granted Medicaid SOBRA eligibility within the 60-day deadline, is the Primary Contractor considered to be non-compliant if they are unable to bill Medicaid and pay subcontractors within 60 days? AMA Response: No the 60 days will not be applicable for retro Medicaid.

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84	Op Man, p. 47	VIII, D., 4., e	Administrative Review – Currently, billing and claims associated with dropouts who move away are being held until the EDC (as suggested by Medicaid) to assure that the recipient doesn't return to district to deliver. Given this policy, could the requirement that administrative reviews be submitted within 5 days be removed? AMA Response: Yes.
85	Op Man, p. 53	D. DHCP Report Cards 1st Paragraph, last sentence	Sixty (60) day notice of change in performance measures may not be sufficient depending upon the measure and the date the measure is done. For instance a lab service performed at the initial visit will already have been done several months prior to a change with a 60 day notice AMA Response: The 60 days would be prior to the effective date so previous labs would not be applicable.
86	Op Man, p. 53	D. DHCP Report Cards	Can this information be collected by: DHCP staff? Hospital QA staff? RN Care Coordinator? Designated/trained clerical staff? Other? AMA Response: Any or all of the above.
87	Op Man, p. 53	IX., C.	Concurrent with the above question, if the recipient's eligibility is late, the Primary Contractor would be unable to enter the required information into the service database for these patients who have not been granted Medicaid SOBRA eligibility within the 60-day deadline. In this situation, will the primary contractor be considered non-compliant? AMA Response: No.
88	Op Man, p. 53	Attachment I, 1.	Where did Medicaid get the Benchmark standards for the 7 listed? AMA Response: The benchmarks were established by a group of OB/GYN physicians from across the State.
89	Op Man, p. 54 ***	Attachment I, 3. Measurement Standards	If one looks at the chart, it appears that you audit anywhere from 100% to 35% of a DHCP's global deliveries. If one looks at the writing (every ninth name), it appears that you audit 10% to 4%. If one looks at the chart and the writing, it appears that you audit < 5%. Medicaid had historically audited 5%. Please clarify the Sampling Methodology as bid price will be greatly affected depending on the clarification. AMA Response: The ITB will be amended to delete the chart and the narrative will be amended to state the following: The Primary Contractor must perform a minimum of 5% random sampling of each DHCP every 6 months for measurement of the required elements and development of professional report cards.
90	Op Man, p. 55	IX. D.4.	In the 2008 ITB there were questions about the chart that appears on page 55 of this ITB's Operational Manual. We didn't understand it last year and we still do not understand it. It would help us if you use the scenario below to tell us how many charts would need to be reviewed using the chart on p. 55. We need this information to determine staff needs for QAPI DHCP Practice# 1 — DHCP ID# 102 — Number of Del in six months 17 — Number of records to review

			1 113 63 1 125 27 2 103 102 2 105 30 4 117 44 Total deliveries/charts to review: 283 AMA Response: Refer to question 89.
91	Op Man, p. 55		"Samples will be drawn using the following chart indicating the sequence of record selection (every ninth name)." The chart that follows indicates records will be pulled dependent upon the number of records/deliveries in that period. For staffing purposes help us understand: If a provider has over 200 deliveries in six months how many records would you require to be reviewed? AMA Response: Refer to question 89.
92	Op Man, p. 55	Attachment I, 4. Delivering Health Care Professionals Sampling Methodology	"The bonus payments will be calculated within six months of the end of the annual contract date and are contingent upon the availability of funds." What priority of availability of funds will Medicaid give the Performance Incentive Measures? Several of the measures will be finically burdensome and without knowing Medicaid's priority of payment it could leave a Primary Contractor vulnerable. AMA Response: All payments of any type made by the Agency are dependent on the availability of funds. No priority can be stated.
93	Op Man, p. 55	IX.D.4. Delivering Healthcare Professional Report Cards *******	Is 65 the maximum number of charts to be audited per DHCP group/practice? Previous response to the 2008 ITB Pre-Bid Questions: A: The numbers reflected are per DHCP. You may have multiple DHCPs in a practice. If the practice is s true clinic practice in which the patient routinely sees differing DHCPs, the number is to be applied to the clinic practice. The "number of charts" to be reviewed is a guideline, not the definitive number. For a population size greater than 200, there should be no number "65". The instructions associated with that line say to pull first ordered record, skip the next two records", i.e., a thirty-three percent sample. The "number sampled" here is actually indeterminate, because the size of the population, i.e., 200 or greater, is actually open-ended. The chart will be corrected through amendment. Will this chart be corrected through amendment? . AMA Response: Refer to question 89.

<table>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>94</td><td>Op Man, p. 55</td><td></td><td>Medicaid's QA division will use the same sampling methodology for their reviews.

Will the Agency request the same number of charts from the Delivering Health Care Professionals that the Primary Contractor is required to review?

AMA response: Yes

Q16. <u>Operational Manual, pg. 71, Section XI. B. 3. Administrative Reviews:</u>

<table><tr><td>MEASURE</td><td>PENALTY</td></tr><tr><td>Application Assister Services</td><td>$500 per week that there is no Application Assister in all counties; Primary Contractor must submit a list of counties and names of assigned Application Assisters monthly.</td></tr></table>
Are there a minimum number of days that an Application Assister must be available in a given county? For example, would it be acceptable to have an Application Assister available in a given county one day a week?

AMA Response: Question 1: No. Question 2: The AMA expectation is that the bidder meets the requirement of the ITB. There is no specific requirement that an application assister be physically located in each county only that the PC offer/provide this function to all maternity patients.

Q17. <u>Operational Manual, pg. 39, Section VI.D. Subsequent Encounters and Operational Manual, pg. 72, Section XI. C. 4. Medical Record Reviews:</u>

<table><tr><td>MEASURE</td><td>WHAT IT IS</td><td>EXPECTATION</td></tr><tr><td>Content of Care Coordination</td><td>That required encounters met the guidelines specified in Section VI of the Operational Manual. For example: were risks identified? Were referrals made that addressed specified risk(s)? Were appropriate forms completed?</td><td>90% of the encounters meet the required guidelines.</td></tr></table>
Operational Manual, pg 39, Section VI. D. Subsequent Encounters specifies some requirements that would not be applicable at this visit.</td></tr>
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			Since there is a $500 per recipient penalty if Content of Care Coordination is determined to be below established benchmark with no improvement noted for the 2nd occurrence, could the exact criteria for the composition of the encounter to be completed while the mother is still in the hospital after delivery be specified? AMA Response: Agency expectation is that the element requirements will be covered. If there are only 2 encounters, all requirements not covered on the first encounter must be covered on the face to face hospital encounter. Please remember that the Care Coordinator has the flexibility to schedule the number of visits encounters according to the recipient needs.
95	Op Man, p. 57 & 63 **	a, 5 "…21 to 60 days" & Performance Incentive Measures, d "…21 to 60 days"	Would Medicaid consider the days to be <u>any postpartum days after delivery through the end of the postpartum coverage time</u>? The reason is some providers give some birth control such as Depo as early as hospital discharge and 1-2 weeks. Also most providers want the patient on their menses in order to receive the Mirena. These patients will not be counted in the percentage if only 21-60 days are considered, yet we do not want to promote waiting until 21 days for Depo if 1 week is working. True utilization of family planning will not be reflected if expanded time periods are not considered AMA Response: Yes. The ITB will be amended to reflect this change.
96	Op Man, p. 59	IX.G	Can implementation of the Centering Pregnancy Program count as the Quality Improvement Activity? AMA Response: No
97	Op Man, p. 63	Attachment I, L.	"The establishment and/or maintenance of at least one Centering Pregnancy site for the entire year per district." Does the site have to be a "Centering Healthcare Institute" certified site or can it be modeled after the Centering Pregnancy model? AMA Response: Yes, it must be a certified site.
98	Op Man, p. 63	Attachment I, b.	"A bonus of up to 5% of the payments for that contract year may be awarded to the Primary Contractor…" Are the incentive payments available for each year of the contract or just the first year? AMA Response: All payments made by the Agency are dependent on the availability of funds, but the goal is to be able to make incentive payments for each year of the contract. Will the benchmarks remain the same for the entire contract or does Medicaid have the right to change those benchmarks? AMA Response: We anticipate that the bench marks will remain the same.
99	Op Man, p. 63	IX.L.	The second sentence of the first paragraph provides that payments will be calculated and payment is contingent upon the availability of funds. Does Medicaid anticipate funds to actually be available in light of the current economy? Have these funds been reserved to date? If paid, when should

			payment be expected? AMA Response: All Medicaid payments are based on the availability of funds. The incentive payment is anticipated to be made 6 months after each contract year.
100	Op Man, p. 63	IX.L.b.	Must the centering pregnancy site be operational immediately at the beginning of the contract period to receive that portion of the bonus in year one or is there some grace period for year one of the contract period? AMA Response: No but it must be operational by the end of the first contract year to qualify for the incentive payment.
101	Op Man, p. 63	IX.L.d.	This section provides that 85% of all delivering women must complete a family planning visit between postpartum day 21 and 60. Who must conduct this visit? Is this in essence adding another required care coordination contact if this portion of the bonus is to be earned? AMA Response: The visit is conducted by the DHCP or a family planning clinic or physician. It will be up to the Primary contractor to obtain the documentation to support the bonus incentives.
102	Op Man, p. 63	IX.L.c.	Does the reference to "all diabetic women" include those presenting with diabetes and those that contract gestational diabetes during pregnancy? Also, what is required for the Primary Contractor to receive credit for this benchmark. Is it sufficient to make the appointment with the dietician for the Program Recipient or must the Program Recipient actually complete the visit? AMA Response: Question 1, Yes both those presenting with Diabetes and those that contract gestational Diabetes. Question 2, The Primary Contractor must have documentation to support that the visit was completed by the dietician.
103	Op Man, p. 64	f	"…a minimum of 25% of the total of number of deliveries served are identified as breastfeeding mothers at their postpartum visit." How will primary contractors know if the patient is still breastfeeding or still ceased from smoking at the DHCP postpartum visit, when the care coordinator's last visit with the recipient is in the hospital? The DHCPs currently do not record whether the patient is still breastfeeding or still not smoking at the postpartum visit. AMA Response: It will be up to the PC to establish a mechanism for this information such as working with the physician to gain the information at the postpartum visit or phone calls to the recipient.
104	Op Man, p. 64	IX.L.g	This section provides that a portion of the bonus is contingent upon 75% of the annual district deliveries have the first doctor's visit conducted at less than 14 weeks gestation. Aside from community outreach provided by providers, there is no way for a provider to make sure the first visit is conducted within the time frame if the patient does not present for enrollment until after such date. Can this standard be replaced with something that the Provider has more control over? AMA response: No.